

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF LICENSING PROGRAMS

TECHNICAL ASSISTANCE

On
Assisted Living Facility Regulations
Effective: December 28, 2005

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Standard 55

Question: Disclosure form: Will there be a form for providers?

Answer: Yes. The required form is available on the DSS public web site. The disclosure form and instructions for the form are available at <http://www.dss.virginia.gov/form/word/032-05-849-1.doc>.

Question: Do all fees need to be included on the disclosure (e.g., additional charges for services)?

Answer: Yes. The disclosure statement must include all fees charged for accommodations, services, and care, including clear information about what is included in the base fee and any fees for additional accommodations, services, and care.

Question: Can the agreement just reference the disclosure and vice versa? Some of the information is the same.

Answer: The information should match between the disclosure and the resident agreement. For example, the fees should not have different amounts for the same things. However, you can't just reference each. Although some of the information in the disclosure and the agreement are the same, some of it is different and the two documents serve different purposes. The disclosure information has to be on the DSS form, whereas there is more flexibility in the format of the agreement.

Question: For the criteria for admission, the reader is referred from the Disclosure Statement to "See attached Admission Criteria Sheet." Should we allow required descriptions to be in attached documents or must all requirements literally be in the "Disclosure Statement"?

Answer: All required information for the disclosure statement must be on the DSS form; reference to other documents in place of including the information on the disclosure form is not acceptable. Prospective residents and others need to be able to obtain information on a facility and compare facilities in an efficient and effective way. Having to search through other documents to find the required information would make the whole process more complex and difficult and perhaps unwieldy for prospective residents and others.

Question: Where criteria are mentioned, how explicit will the facility need to be, or is there acceptable phrasing, "including, but not limited to..."?

Answer: All criteria must be included, or else it would be impossible to accurately compare facilities.

Standard 55 (continued)

Question: Does the facility have to disclose the information to the prospective resident if he does not ask for it?

Answer: Yes.

Question: The disclosure statement includes the names of any other facilities for which the licensee has been issued a license by the state. An entity may own some facilities, manage others, and have partial ownership in others. What should be included on the disclosure statement?

Answer: What is to be included in this section are those facilities that have the same licensee. This does not include ALFs that are only managed by an entity or other licensees in which some or all of the same individuals are involved.

Question: One of the items requires indication of whether contractors are used to provide essential services. Please provide guidance on what are “essential services.”

Answer: “Essential services” includes staffing services, pharmacy services, health care services and food services. It also includes other services provided by contractors on a regular basis that directly affect the health and safety of residents.

Question: When must the disclosure statement be given in the event of an emergency placement?

Answer: After an emergency placement, a person may remain in an assisted living facility for no longer than seven working days unless all the requirements for admission have been met and the person is admitted. This provision is found in Standard 150 S. The standard regarding disclosure includes an exception that provides for circumstances when the disclosure statement cannot be provided at least five days in advance, which would likely be the case in an emergency placement. This exception requires the statement to be given to the person at the earliest possible time prior to signing an admission agreement or contract. In an emergency placement, the disclosure statement would have to be provided to the person no later than seven working days after placement and prior to signing an admission agreement or contract.

Question: The names of contractors that need to be provided is upon the request of whom, i.e., does it include the general public or just prospective residents?

Answer: The names of contractors must be provided upon the request of prospective residents and the general public.

Standard 55 (continued)

Question: Does disclosure of health care services include services provided to individuals, such as physical therapy, oversight provided by sitters? How broad or narrow is the interpretation for health care services that must be included in the disclosure statement?

Answer: The disclosure statement must include those health care services that are offered by the facility, whether provided directly by the facility or by an entity with which the facility contracts. Therefore, if the facility offers physical therapy, for example, it would need to be included on the disclosure statement. The disclosure statement would not include those health care services obtained directly by the resident. So, if the facility does not offer physical therapy, but the resident or the resident's family makes arrangements for a physical therapist, this would not be included on the disclosure statement. Most sitters are probably the result of arrangements made by the resident or his family and would not be included on the disclosure statement if such was the case.

Standard 60 H 1

Question: What are considered day shift hours?

Answer: The day shift may vary depending upon the facility, but would generally be somewhere between the hours of 7:00 a.m. to 6:00 p.m.

Standard 60 I

Question: Do acting administrators have to work the same number of hours?

Answer: Yes, an acting administrator must work the same number of hours as required for the administrator.

Question: What would be considered "qualified" in regards to the acting administrator?

Answer: The definition of "qualified" is found in Standard 10. It means having appropriate training and experience commensurate with assigned responsibilities; or if referring to a professional, possessing an appropriate degree or having equivalent education, training or experience. This definition allows for some flexibility in determining whether or not a person is "qualified" to be an acting administrator. An example that might be allowed by this flexibility would be an acting assisted living care level administrator who had one year of college in courses unrelated to human services or group care administration and two years of experience in caring for adults with mental or physical impairments in a group care facility. It is important to note here that all cases must be given individual consideration in making a determination of whether or not a person is qualified to be an acting administrator.

Standard 60 K

Question: Medication aides may be supervised by an individual employed full time at the ALF who is licensed by Virginia to administer medications. Is supervision immediate, 24/7, does having an RN or LPN on staff full time, with supervision of medication aides as part of their responsibility, meet the exception if they do not cover all shifts?

Answer: The standard does not require on-site supervision 24/7. Having an RN or LPN on staff full time who supervises the medication aides is fine. An RN or LPN does not have to be present at the facility on all shifts, but is responsible for supervising the medication aides.

Question: Administrator medication training: What if full-time RN or LPN leaves the staff?

Answer: If the administrator has not completed the medication training program, is not licensed by the Commonwealth to administer medications, and there are no other persons employed full time at the facility who are licensed by the Commonwealth to administer medications, the facility would be out of compliance with this standard (unless the administrator was newly hired within the past four months). In the case in question, it would be necessary for there to be a full-time replacement or a temporary full-time individual who is qualified, or the administrator would have had to successfully complete the medication training program by the time the RN or LPN left the staff.

Standard 60 L

Question: Regarding a shared administrator for smaller facilities, if the administrator has two facilities, each with 10 or fewer residents, is he only required to spend 10 hours at each or does time (40 hours) have to be divided up, such as 20 hours each? Can he spend 10 hours at one and 30 hours at another?

Answer: The administrator must serve as administrator for at least 40 hours a week. If he is the administrator of two facilities, each with 10 or fewer residents, he can spend 10 hours at one facility and 30 at the other. The time can be divided evenly or not, but the administrator must spend at least 10 hours per week at each facility, and must spend at least 40 hours a week as administrator.

Question: Regarding the requirement for facilities to be within a 30 minute average travel time, does this include a central office? Does it include exceptions for time of day?

Answer: The facilities to which this standard refers regarding travel time are the ALFs, not the central office if it is at a separate location. There is no exception for the time of day.

Standard 60 L (continued)

Question: Why have an assistant administrator and a manager?

Answer: The assistant administrator, who must meet the qualifications of the administrator, may only serve when the administrator is ill or on vacation. The manager serves on a regular basis for the part of the 40 hours that the administrator or assistant administrator is not present at the facility.

Question: Can the manager and designated assistant administrator be the same person?

Answer: Yes, as long as the individual meets the qualifications for both positions. Please note that the designated assistant must meet the qualifications of the administrator, and such being the case, there would be no need for a “manager” position, i.e., it would not be considered a shared administrator situation as allowed for in Standard 60 L.

Question: Will all administrators and all managers be required to attend refresher training, and all new managers? Is this Phase II training?

Answer: The managers in the smaller facilities are required to attend the refresher training, unless determined otherwise by the department. There is no requirement in the regulations that the administrators in smaller facilities attend this training. The refresher training is not the Phase II training, which does not necessarily cover all new or changed requirements. The refresher training is on new or revised standards. New managers that start employment after the training in the new/revised standards is over are not required to attend refresher training, unless the standards are again changed.

Standard 65

Question: Can the direct care staff member, if he meets qualifications, be in charge 24/7, which means the administrator does not have to be on the premises?

Answer: It is not clear what qualifications are being referred to in the question. There must be an administrator or designed assistant who meets the qualifications of the administrator on the premises at least 40 hours per week.

Question: Can there be any limits imposed on access to records by the designated staff person in charge?

Standard 65 (continued)

Answer: The designated staff person in charge needs to have access to all records that are related to the care of residents. The person does not necessarily have to have access to financial records. Regarding personnel records, the person in charge needs to have access to emergency information and also information on a staff person that may impact resident care.

Question: What is “reasonable” access to records?

Answer: The Code of Virginia, § 63.2-1706 provides that “... licensees shall at all times afford the Commissioner reasonable opportunity to inspect all of their facilities, books and records....” A record that a licensing inspector wants to see may not be available when the inspector is present at a facility because the designated staff person in charge does not have access to that record. In order to conform to the Code, the administrator or another person known to the designated staff person in charge must be able to be contacted to make the record available while the inspector is at the facility, without the inspector having to wait for an unreasonable amount of time. “Reasonable” and “unreasonable” are relative terms that are not translated into a set period of time, such as an hour, that would apply to all cases. It is hoped that there will be agreement between the facility and the inspector as to what constitutes “reasonable.” The facility is responsible for having arrangements in place so that an inspector will have “reasonable” opportunity to inspect the records.

Please keep in mind that Standard 180 D requires all records that contain the information required by the standards for both residents and personnel to be retained at the facility and kept in a locked area. Standard 180 E requires that the licensee assure the records are treated confidentially and that information is made available only when needed for care of the resident. In addition, Standard 180 E specifies that all records must be made available for inspection by the department’s representative.

Question: Does the designated staff person in charge have to be the same person or can it be several over the week?

Answer: The designated staff person in charge does not have to be the same person all the time. There can be several designated staff persons in charge over the week.

Question: Does the facility need to document the designated staff person in charge on a staff schedule or elsewhere?

Answer: There is no requirement in the regulations for documenting the designated staff person in charge on a staff schedule or elsewhere in writing. However, all staff present in the facility when the designated staff person is in charge need to know who this person is, and it is advisable

Standard 65 (continued)

to place that information in writing. It is also advisable to maintain that information as evidence of compliance with the requirement to have a designated staff person in charge.

Standard 80 E and 630 H

Question: Regarding training for new direct care staff, when does the time frame of no later than 60 days after employment take effect? For example, what about staff who began employment in July 2005?

Answer: Direct care staff hired prior to December 28, 2005, which is the effective date of these regulations, have a year from their date of employment to obtain the required annual training, and the 60 days after employment to begin the training does not apply to them. Therefore, a direct care staff person who was hired in July 2005 must begin and obtain the required annual training within one year from the date the person began employment, that is, the training would have to be completed sometime in July 2006, and there would be no set date by which this training was to have begun. A direct care staff person who begins employment on or after December 28, 2005, is required to begin training not later than 60 days after employment and to obtain the required annual training within one year from the date the person began employment.

Standard 120 A, B, C & D

Question: Do direct care staff trained in CPR/First Aid have to use their training/skills in an emergency?

Answer: Failure to provide care to meet the needs of a resident is a key health and safety violation. Our expectation is that properly trained staff will respond appropriately, use common sense, and a reasonable level of skill; not exceed the scope of their training in emergency situations; do their best to save a life or prevent further injury to the victim; and call 9-1-1 or another emergency number if the ill/injured individual needs assessment or treatment from a trained health care professional. Please note that this does not override Standard 410 regarding Do Not Resuscitate (DNR) orders.

Question: What does “available” mean in the context of direct care staff trained in CPR?

Answer: It means that a person trained in CPR shall be available if necessary to assure quick access to residents in the event of the need for CPR. The individual certified in CPR, for instance, must be in a position so that the person can be reasonably expected to begin CPR for a resident within 4 minutes if a need for assistance in a cardio-pulmonary event should occur.

Standard 120 A, B, C & D (continued)

Question: Can you explain why Standard 120 A and Standard 120 C do not contradict each other?

Answer: While we realize that there seems to some to be a conflict with Standard 120 A, it is important that everyone understand that the intent for Standard 120 C is that those non-licensed individuals responsible for direct care and supervision of residents will have basic first aid training certification as a condition of employment in those positions. These are the people who will most likely be present to witness an accident, injury, or the acute onset of an illness and need to be prepared to take appropriate action before nursing or emergency medical personnel arrive on the scene.

Standard 120 C gives new staff 60 days to obtain certification in first aid. If new staff are not yet certified, compliance with Standard 120 A guarantees that there will always be at least one person who has current certification unless there is a licensed nurse on duty.

Standard 120 F

Question: This standard requires that an employee with current certification in first aid and CPR be present during facility-sponsored activities off the facility premises. If there is a trip to a shopping mall, which a facility considers a “facility-sponsored activity,” would there have to be an ALF staff member with first aid and CPR certification who stays at the mall? The facility takes residents to the mall where the residents go wherever they wish and later gather at a predetermined location so that the facility can take them back to the ALF. Does the employee with first aid and CPR certification have to sit in a central location while the residents are shopping in various stores?

Answer: For the purposes of this standard, “facility-sponsored activity” refers to those activities where ALF staff are present with the residents during the activity and are responsible for oversight of the residents. This does not include trips to the mall as described in the question. There does not have to be an employee at the mall while the residents are shopping in various stores. It is important to note that residents who are taken places and then are on their own while there must be capable of being on their own without endangering themselves or others. These residents must be able to appropriately care for themselves during the activity and able to be responsible for protecting their own health, safety and welfare during the activity.

Standard 150 B

Question: Are emergency placements exempt from the mental health pre-admission evaluation?

Standard 150 B (continued)

Answer: The mental health pre-admission evaluation, when recommended as specified in 150 B 4, is needed within seven working days of emergency placement, if the person is admitted, according to Standard 150 S.

Standard 150 B and P

Question: Does the qualified mental health professional (QMHP) have to be independent of the licensee?

Answer: Yes. The QMHP must be independent of the licensee to avoid a conflict of interest or the appearance of such. Standard 150 P 3 c requires that the QMHP have no financial interest in the ALF.

Question: What if the CSB or other QMHP does not respond to a request for an assessment?

Answer: If the CSB states that it cannot conduct the evaluation, the facility or the UAI assessor who makes the referral should contact the Division of Licensing Program's mental health operations consultant (804-726-7141). If the QMHP is in private practice and states that he or she cannot conduct the evaluation, the facility should try another QMHP.

Question: How will a referral for a mental health evaluation be made for a private pay resident if the facility only completes the short form of the UAI for private pay?

Answer: On page 2 of the short form of the UAI, the assessor is asked whether a current psychiatric or psychological evaluation is needed. This determination is based on assessment protocol used by the facility for private pay residents, rather than the psychosocial assessment section of the UAI used for public pay residents.

Question: Do we include residents who have a diagnosis of dementia? If yes, it would seem that the majority of Alzheimer's residents would require this type of assessment. Also, would this assessment be in addition to the assessment that is required for residents in a special needs unit?

Answer: Standard 150 P applies to any person when warranted by the level of dysfunction exhibited by the individual. The level of dysfunction may include, but is not limited to, specific indicators listed in Appendix K of the UAI and Standard 150 P 1 a-g. While a person with dementia does not need an evaluation simply because he has a number of deficits in ADLs and IADLs, if he has a behavioral disorder such as aggression, intrusive behaviors that provoke

Standard 150 B and P (continued)

aggression, or some type of obsessive compulsive behavior that may lead to risk of harm, etc., then an evaluation would be appropriate.

If a person with dementia is being considered for admission to a special care unit, then the assessment requirements under Standard 700 C must be met. Two different evaluations are not required.

Standard 150 P

Question: With respect to obtaining a mental health evaluation that was recommended for a prospective or current resident, § 62-1805 B, states that “The Department shall not take adverse action against a facility that has demonstrated and documented a continual good faith effort to meet the requirements of this subsection.” How should the facility demonstrate and document a continual good faith effort to have a mental health evaluation completed?

Answer: While we must take this part of the Code into consideration, this language is intended to convey that the facility, when a timely and proper referral has been made, will not be sanctioned if the mental health service provider does not respond promptly. However, it does not mean the facility will not be cited for not having the evaluation prior to admission for a prospective resident or in the case of a current resident, within a reasonable period of time. The administrator has the responsibility to ensure that the facility can meet the needs of the resident, to include the consideration of any condition(s) that might put the person or others at risk for harm. The following guidance is provided as to what administrators must demonstrate and document regarding their efforts to ensure that a mental health evaluation is completed.

If a recommendation is made by the UAI assessor, health care professional, or facility administrator (designee) to have a formal mental health evaluation conducted by a QMHP, the facility may approve a tentative admission for a prospective resident or retention for a current resident provided that:

- (1) the facility’s decision to admit or retain, without the pending assessment, is based on a careful consideration of the person’s emotional or behavioral functioning that could signal high risk concerns for the health and safety of the resident or others;
- (2) the facility has developed a preliminary plan of care that appropriately addresses any identified concerns to a degree that the resident is not considered high risk for harm to self or others;
- (3) regarding the prospective resident, the facility has been informed by the QMHP as to the expected date of completion of the mental health evaluation and the facility has determined that the length of time to have the evaluation completed and forwarded to the facility would cause hardship for the individual or his family;

Standard 150 P (continued)

- (4) the preliminary mental health assessment contained in the UAI (appendix K) and the required collateral information when appropriate (see 150 P 5) were used as part of the information required to determine the appropriateness of admission or retention;
- (5) the facility follows up with the disposition of the mental health evaluation and, upon receiving it, re-evaluates its ability to meet the needs of the resident regarding the mental health care/supervision that might be needed;
- (6) the facility clearly documents all efforts made to get the mental health evaluation completed;
- (7) the facility meets all other admission or retention decision requirements, e.g., completed UAI, physical, and no prohibited conditions.

Question: Is there a difference between the evaluation required in Standard 150 P and the evaluation required in Standard 485?

Answer: Yes, there is a difference. The intent of Standard 150 P is to identify any prospective or current resident who displays a level of functioning warranting an evaluation to determine the need for mental health services. Without the appropriate services, the resident would be considered at risk for further decompensation or for being unable to reach his highest level of independent functioning. The intent of Standard 485 A 1 is relevant to a current resident who is experiencing an acute mental health emergency involving a substantial risk of harm to the resident in crisis or others. In this situation, the facility needs to contact the local CSB to have an evaluation of the need for emergency intervention, which may include psychiatric hospitalization. The intent of Standard 485 A 2, however, is consistent with Standard 150 P in that the requirement for an evaluation addresses a non-emergency need for mental health services.

Question: Will a form be developed detailing the areas needing to be covered in a mental health assessment to comply with the standards?

Answer: At this time, a standard form will not be developed for providers to send to an agency, e.g., a CSB, conducting the evaluation. While the format or structure of a mental health assessment might vary from one QMHP to the next, the content areas covered will generally be consistent. The administrator is not expected to have the skills of a mental health assessor to make a determination that an assessment meets certain standards of practice in the clinical field. Instead, the expectation is that the administrator will review all areas covered in the assessment, e.g., cognitive functions, thought and perception, mood/affect, behavior/psychomotor, etc., and confirm on the *Mental Health Services Determination Form*, Part I, question 10 that the assessment was used in determining the appropriateness of admission or retention. One other point is that the administrator (designee) is responsible for completing the *Mental Health Services Determination Form*, not the QMHP or the referring party such as a hospital or another ALF.

Standard 150 P (continued)

Question: What if the UAI does not show documentation of these observed behaviors and, therefore, does not make a referral for an evaluation, but the facility staff documents in the progress notes that these behaviors are present? Is the facility now required to ensure the individual is evaluated?

Answer: If the UAI assessor fails to uncover a condition that meets 150 P 1 (a-g), but information obtained or behavior observed by the facility shows the presence of such a condition, the facility should notify the UAI assessor of this. However, there is no specific standard that requires this communication. The additional information may change the recommendation of the UAI assessor with respect to making a referral for an evaluation. If the facility has collateral documentation or information that strongly suggests that the facility should be concerned about the dangerousness of the person's behavior, and the UAI assessor still does not recommend a referral, or the facility fails to provide the additional information to the UAI assessor, then the facility has the responsibility to seek an evaluation. In other words, in the absence of a UAI assessor or other professional health care provider's recommendation for a referral, the facility still must make the referral if there is evidence that indicates the need for an evaluation.

Standard 150 P 1

Question: Under the criteria for this assessment, the list states (under f) significant dysfunction in two or more of the following areas: interpersonal communication, problem solving, personal care, independent living, education, vocation, leisure, community awareness, self direction, and self-preservation. The concern is that this will subject most persons who qualify for the assisted living level of care to require an assessment.

Answer: While conditions listed under Standard 150 P 1 (a-g) must be considered for all prospective or current residents, the degree of impairment in any particular area may not rise to a level that would warrant having a mental health assessment performed. A behavior that might be considered high risk for one person may not be for another. When determining whether to refer a prospective or current resident for a formal mental health assessment, the preliminary findings of the UAI assessor or facility administrator are based on indications of serious maladaptive functioning that may be in need of professional mental health interventions.

Question: What's maladaptive behavior (listed under e)?

Answer: Maladaptive behavior is any behavior determined by a societal or cultural standard, or a professional person trained in analyzing behavior that is considered to be markedly different from the norm. In a nutshell, a maladaptive behavior is what the word implies, i.e., not conducive as a means to satisfy a need or desire in a socially acceptable way. Examples of

Standard 150 P 1 (continued)

maladaptive behaviors could be pacing floors without apparent reason, striking out at a person who enters into one's personal space, hoarding food, causing injury to self or commotion to get attention, engaging in injurious behaviors to self or others to satisfy an emotional and psychological need, engaging in repetitive behaviors such as excessive hand-washing to alleviate a phobia, and excessive drinking of alcoholic beverages or routinely using drugs not prescribed by the medical profession to alter one's psychological and emotional state.

Standard 150 P 3

Question: How is inadequate assessment by a QMHP cited?

Answer: If the licensee accepts or retains a resident without a complete assessment, then the appropriate part of Standard 150 P 3 b (1-9) is cited. It is not intended for the inspector to assess the quality of the assessment, only to determine whether or not the administrator considered all parts of the assessment in making the admission decision. If a mental health assessment was done, the inspector should review the response to question 10, Part I of the Mental Health Services Determination Form. However, as stated, if the assessment has not yet been received by the facility from the QMHP, but the facility still chose to admit or retain, the facility must be cited. The comment section of the violation notice shall reflect the status of the assessment.

Question: Will there be a model form to address the areas to be covered under 150 P 3 b (1-9)? If not, I believe it will be difficult to ensure that the Mental Health Professional covers all of the required areas.

Answer: A model form will not be provided at this time. It is expected that assessments performed by mental health professionals comport with standards of practice for conducting comprehensive mental health assessments. Areas required under Standard 150 P 3 b (1-9) are considered standard areas covered in a comprehensive mental health assessment. The assisted living facility is responsible for ensuring that the QMHP is aware of the requirements under Standard 150 P 3 b (1-9).

Standard 150 P 5

Question: Does the standard apply to a resident with a mental health disability who was hospitalized for a medical condition not related to the MH diagnosis?

Answer: If a resident has been hospitalized for a medical reason and is now seeking admission into an ALF, and there are one or more conditions specified under 150 P 1 (a-g) existing within 6 months of the admission, then 150 P 5 applies. This standard requires the facility to consider supporting documentation and collateral information gathered as specified before deciding to

Standard 150 P 5 (continued)

admit a resident with mental health problems. If the resident has a history of mental health problems but the conditions listed in 150 P 1 (a-g) have not been observed within the past 6 months, then neither supporting documentation nor collateral information is needed, nor is an evaluation required.

Question: Do facilities have any leverage to ensure that those parties referring residents to them provide information that is needed and accurate to help decide the appropriateness of admissions?

Answer: We cannot guarantee and neither can the ALF ensure that the collateral information will be 100% accurate. However, by requiring the facility to request the information in writing, it will, at least, hold the referring facility accountable, to some degree, if the ALF finds out after the person has been admitted that the referring agency inaccurately presented medical or mental health problems of a resident. The facility should report problems with obtaining the proper information to the administration of the referring agency. The facility may elect to not accept future admissions from that source if that source isn't forthcoming with accurate information.

Question: How do facilities obtain collateral information? What if the discharging facility will not provide collateral information?

Answer: Facilities should already have policies and procedures in place for requesting information from a referring facility/agency. The expectation is that the facility request information over the period specified in the standard that reflects how the resident has functioned. The information can be daily progress notes, monthly summaries, or any other document that covers the specified period of residency and provides information about functioning. If the discharging facility refuses to provide the collateral information, the facility cannot accept the resident.

Standard 160 I

Question: Does it violate HIPPA to disclose to the receiving facility why the person was discharged?

Answer: No. The Code states that collateral information must be given to a facility considering the admission of a person with a questionable mental health status. The purpose of HIPPA is to prevent the unlawful use of personal medical information. It is a general expectation now that when a resident is referred to another facility or hospital, a release of information form is signed either by the resident or the legal representative.

Standard 400 A

Question: Which standards require adherence to the medication management plan?

Answer: Standard 50 A. “The licensee shall ensure compliance ... with the facility’s own policies.” This required plan will be the facility’s policy related to the management of medications.

Standard 400 A 1 b

Question: How should a facility determine time schedules for routine medication administration if the prescriber does not specify?

Answer: Each facility should have a time schedule for administering drugs. This would be included in the elements in standard operating procedures and any general restrictions specific to the facility.

Nursing students are taught this during the pharmacology portion of their basic training, and it is included in the med aide training with the following notation: “If you do not (*have a facility-established time schedule*) your pharmacist can help you with a frequency chart that would be appropriate.” The refresher course includes a similar comment in the instructor materials (page 15) – “Pharmacists can work with physicians and administrators to establish reasonable administration times for the medications prescribed.”

The basic standard of practice is that medications that are not otherwise restricted to more specific administration times will be administered no sooner than one hour before the scheduled time and no later than one hour after the scheduled time. When a resident’s circumstances are such that the resident is not available at the scheduled time, chart documentation should explain the reason (an MD appointment, out with family, etc.) and what actions were taken as a result (administered upon return, not administered-too close to next scheduled dose, MD notified/called for directions, etc.)

Standard 400 A 2

Question: Do I have to send a copy of my facility’s medication management plan to my inspector for review prior to my next inspection? Will I get an approval letter if the plan is accepted?

Answer: Your inspector may request, but cannot require, that you submit a copy of your plan prior to the inspection in order to facilitate the inspection process and reduce the amount of time required on-site at your facility.

Standard 400 A 2 (continued)

The assigned inspector will be reviewing whatever document(s) you have in place during the next on-site inspection. Approval of the plan will be verified in the inspection process by virtue of determining compliance with the required elements in the related standards. This will be so noted by the inspector in the comment section of the inspection summary. The inspector will then review any subsequent changes in the facility's medication management plan and document compliance using the same process. Individual "approval letters" will not be issued.

Standard 400 A 4

Question: How do providers get a copy of the approved medication aide training entitled A Resource Guide for Medication Management for Persons Authorized under the Drug Control Act?

Answer: Providers can contact the Virginia Geriatric Education Center (804-828-9060) for a copy of the materials order form to purchase this guide.

Standard 400 B

Question: Why does this standard address physician's oral orders when medication aides cannot accept MD's orders?

Answer: The Drug Control Act does not permit non-licensed individuals to transmit physician's orders to the pharmacist. In those instances where the physician is calling the order to the facility, the physician must also place the order to fill the prescription with the pharmacist. The medication aide can take orders to administer the medications as prescribed. They must be careful to obtain full instructions and compare those to the directions on the pharmacy label when the medications are delivered.

Standard 400 C

Question: Is a new order that says "resume previous order" acceptable?

Answer: NO. If the "new" orders do not specify something like "discontinue all meds as ordered prior to hospital stay," the facility staff is responsible for ensuring that it was the intent of the MD to discontinue any drugs not included on the "new" orders. Additionally, staff cannot assume that the treating physician and the primary attending physician are necessarily aware of all medications that have been added, discontinued or started in the interim.

Standard 400 H 7

Question: Can facilities stock over-the-counter medications in bulk for administration to residents as ordered and needed?

Answer: While this standard does not specifically state that bulk medications are prohibited, it clearly states that OTC meds must be in the original container & labeled with the resident's name or in the pharmacy-issued container if unit dose packaging is used.

Standard 400 I & J

Question: What is the difference between the annual in-service and the refresher course?

Answer: The annual in-service can be done by a licensed nurse (pharmacist or physician) and is facility/resident specific. Besides being licensed, the presenter would need to be familiar with the medications and treatments routinely prescribed for the residents of the given facility.

The refresher course that is available from VGEC (see next Q&A) was issued to master trainers and facility and independent trainers in 2000. This training must be provided by trainers registered with VGEC, and the standard clearly frames the required time frame within the year (between 12/28/05 and 12/27/06) for those who have not had the full course or the refresher in at least 3 years.

Question: How do facilities get this refresher training for their med aide staff?

Answer: Training must be provided by a trainer that meets requirements for Medication Management training. The Virginia Geriatric Education Center (VGEC) maintains a list of qualified trainers. The trainer sets the cost for the training. The Virginia Geriatric Education Center (804-828-9060) can be contacted for a copy of the materials order form to purchase the Refresher Course manual.

Standard 400 Q and 650 I

Question: If the attending physician or a physician under contract is willing to conduct the medication review, can the resident(s) be seen in the physician's office or must the reviewer come to the facility?

Answer: The annual (or every 6 months) medication review is designed to ensure that a health care professional considers all prescribed medications, OTCs and supplements that the individual is taking and interviews the resident if indicated. The intent is that someone with a level of professional expertise will look at these more often than the sporadic office visit. It is rare that an attending physician is willing/able to do this consistently. This practice places an additional

Standard 400 Q and 650 I (continued)

responsibility on the facility staff to ensure that the physician sees all orders and MARs and any related care/treatment information. At a minimum, the physician must provide the facility with a signed and dated statement that he has conducted a medication review. The licensed health care professional does not have to come to the assisted living facility unless he deems it necessary to perform the review.

Standard 460

Question: Would aggregating expenses for incidentals/personal care items and then dividing costs at end of month be allowed?

Answer: No. Each resident is to be charged for only those incidentals/personal care items that belong to him. The costs for items for all residents may not be added up and then divided at the end of the month by the number of residents.

Standard 485

Question: When does a behavior become high risk?

Answer: Any behavior that clearly reveals a potential for harm to occur, such as gesturing to hit, is unquestionably a high risk behavior, and must be immediately dealt with. However, other behaviors such as wandering, pacing, or being intrusive of personal space may not indicate a clear potential for a negative event to occur, such as aggression or a sign of psychiatric decompensation. The problem is that a behavior that may be a benign or inconsequential behavior for one person may be a precursor or predictor of a negative event for another resident (or may trigger a defensive retaliation by another resident). Realizing that predicting human behaviors is a difficult task, there are two steps providers should take. First, they need to get to know their residents. They must get to know, document, and communicate to all staffs involved in resident care services the “warning signs” (if known) that a particular resident may give prior to a negative event. It is generally accepted by behaviorists that the best predictor of a future behavior is past behavior. Second, all staffs involved in resident care services must have some basic understanding of the different mental health diagnoses some residents will carry. Staffs must get to know some of the major symptoms or characteristics of the mental health disorders that they will most likely encounter in their facilities.

Question: Must the facility react to every behavior that is listed as an example of a high risk behavior?

Answer: There is no expectation that the facility react to every behavior a resident exhibits, even if the behavior is listed as an example of a high risk behavior, unless it is an obvious precursor or

Standard 485 (continued)

indicator of harm. In order to determine whether a certain behavior can be linked to a certain dangerous outcome, there has to be some level of monitoring and record-keeping. The objective of the monitoring is that when there is a negative event, behavior(s) exhibited by the resident prior to the negative event should be examined. After monitoring for a period of time, e.g., several weeks, there may be sufficient evidence to establish a relationship between certain behaviors and conditions or outcomes. The expectation for the facility is to react to those behaviors that obviously present a danger, and those that are believed, based on knowledge of the resident's history or on expert opinion, to have the serious potential to result in a negative event.

Many adults with serious cognitive impairments exhibit high risk behaviors at various times. Most dementia residents exhibit every behavior described in the definition of high risk behavior at one time or another. However, as stated, a behavior that might be considered high risk for one resident may not be for another. Standards 150 P and 485 do not usually apply when a dementia resident merely wanders into another person's room or speaks incoherently.

Question: It appears that the practice will be to respond to a crisis by taking notes. Will there be a model form?

Answer: The best predictor of future behavior is past behavior. If there isn't some recorded history of past behavior, then it will be difficult to anticipate what could likely happen in the future under similar conditions. Documentation of significant behavioral occurrences or changes is crucial. Responding to a crisis involves not only documentation but steps taken to address the crisis. The behavioral management tracking form has been developed as a model to track serious behavioral disturbances. However, the facility can develop its own form provided that the areas specified in 485 B 1 b (1-8) are covered.

Question: After a crisis the facility does paperwork? Who will train the facility staff to do this? The CSBs, who did not have enough staff to respond to the crisis initially?

Answer: Standard 485 does not require facilities to provide treatment. It requires them to support the treatment services (or any specific care instructions) provided by a mental health agency. If a behavioral management plan is recommended by the CSB or other mental health professional, it will be the responsibility of that party to train the ALF staffs on any relevant parts. The facility must work with the mental health agency to provide needed information in order for the mental health agency to develop an appropriate treatment intervention plan. Both the CSB and facility must understand that if the CSB wants to place its clients in ALFs and ALFs want to admit them, then they must collaborate to make sure these residents are getting mental health services needed. That might mean that the CSB will need to provide in-service training to ALF staffs. There are arrangements like these already in place around the state that ALFs and local CSBs can adopt.

Standard 485 (continued)

Question: Does this standard apply to residents with dementia?

Answer: This standard applies to any resident, regardless of diagnosis, when there is a behavioral crisis or when the facility has determined that the resident's behavior, though not at a crisis level, is problematic enough to justify mental health intervention or discharge. If the facility believes that the resident presents a danger to self or others in a crisis situation, it must call the CSB. Standard 150 F 8 prohibits an ALF from admitting or retaining anyone who presents an imminent risk of harm to self or others. However, upon stabilizing the crisis, and should the facility accept the resident back, the CSB and facility together will decide whether a behavioral management plan is needed to address the ongoing behavioral problems of the resident. If the facility has not determined that a crisis occurred but thinks professional mental health intervention is needed, the facility must contact, within 24 hours, the CSB or other responsible mental health professional to request an appointment for a mental health services assessment.

Standard 485 A

Question: Is a behavior listed as high risk always a high risk behavior for every person?

Answer: A behavior listed under the high risk definition may not necessarily be a high risk behavior for every person. High risk, in part, is determined by knowledge of what outcomes have resulted when certain behaviors have been observed for certain individuals. The list of examples of high risk behaviors is intended to "raise a red flag" for staff to pay closer attention to the resident.

Question: What if the CSB requires the ALF to have a resident TDO'd before an emergency evaluation can be done?

Answer: A temporary detention order (TDO) is issued following an emergency evaluation by the CSB. In the case of an emergency custody order (ECO), the local sheriff or police department can pick up and detain a resident for up to four hours. Within that time, the CSB should have conducted the emergency mental health evaluation.

Question: What triggers the requirement for the facility to call for emergency mental health intervention?

Answer: At any time a behavior has been determined by the facility as presenting a potential risk for harming self or others, then emergency mental health intervention must be pursued. Standard 485 A 1 states "if it is believed (by the facility) that the resident presents a risk of harming self or others..." The trigger for the intervention or emergency evaluation is based on

Standard 485 A (continued)

the facility's own determination, albeit perhaps from a layperson's perspective, that those steps must be taken. The judgment as to whether professional intervention or discharge is needed has always been expected of ALFs. That is why the more staff train on, and consequently understand, basic mental health disorders, symptoms and behavioral crises, the better their decisions and level of comfort will be when determining the type of intervention that is warranted.

Standard 485 A 1

Question: After a significant mental health related episode, most facilities will want to discharge, not retain, a resident. Once a referral is made, what does the facility do in the meantime while it waits for help? Most ALF staffs are not trained for MH crisis management.

Answer: Standards 80 E 2, 630 H and 700 B 4 require facilities to train their staffs according to the needs of the population for whom they are providing care. This includes obtaining training for staff in the crisis management techniques accepted by mental health professionals. However, the use of crisis management is intended to be a short term intervention that is implemented as an effort to keep the crisis from escalating while waiting for the CSB or the police to respond. Again, the facility cannot retain anyone who presents imminent risk of harm to self or others, or for whom their needs can no longer be met. However, if the intervention results in eliminating the imminent risk of harm, the person may be readmitted to or retained in the facility.

Standard 485 A 2

Question: Do all occurrences of any behavior seen as a problem require the facility to contact the person(s) responsible for the mental health care of the resident? How would the presence or absence of a behavior management plan affect this decision?

Answer: With any behavior that does not meet the criteria of a crisis but does raise concerns by facility staffs, the staffs may only need to contact the person(s) responsible for the mental health care once (i.e., for the initial occurrence of the behavior), providing that this decision or response becomes part of an established intervention plan. If there is a plan, it should detail other steps the facility should take to address any future occurrences of the behavior. If no behavioral management plan exists, and the facility has determined that the behavior rises to a level of concern regarding the safety of the resident or others, then the facility must call the person responsible for the mental health care.

Standard 485 B

Question: How is the need for a behavioral management plan determined?

Standard 485 B (continued)

Answer: Following a mental health crisis or other episode of concern, the determination of whether a resident, including a resident with dementia, should have a behavioral management plan will be made by the facility and the person(s) responsible for the mental health care of the resident. A management plan is not automatic even after a crisis.

Question: What are we looking for in the intervention plan? Will a sample of a behavioral intervention management plan be provided?

Answer: If a behavioral management plan has been developed, then there must have been a behavior or pattern of behaviors that triggered it. The development of a behavioral management plan includes the completion of a behavioral management tracking form. Look for the behavior(s) and the interventions prescribed to address the behavior(s). There is a model form called “*Behavioral Management Tracking*” form. There is no standardized behavioral management plan used among mental health professionals, although some may have the heading “*Behavioral Management Plan.*” The plan basically is an assessment of a person’s behavior(s) over time and it attempts to identify and analyze precipitating factors that may have led to the behavior(s) in question. It will contain specific intervention instructions to be followed by those responsible for the primary care of the resident as well as what the professional mental health provider will do.

Question: What is the expectation on the facility to continue to manage the behavioral management tracking form?

Answer: The facility must continue to document on a behavioral tracking form until the mental health agency or other mental health professional says that this intervention is no longer needed.

Question: The mental health tracking and evaluation areas will be a challenge on several fronts. If the evaluations are to be done by neutral parties like CSBs, the responsibility will be placed upon agencies that are hard pressed to manage what they have now. My concern is that facilities will have residents whose needs are undefined or not clearly defined in care while the facility waits for the CSB to evaluate or intervene. Also, facilities may opt not to retain a resident and there are limited options available. Smaller facilities do not have extra time or staff to do “tracking” which, for dementia residents, could be an all day process. The standard does not provide for any time frames and the behaviors to track are very broad.

Answer: Facilities may be hard pressed to take on the extra documentation, intervention, or whatever else a resident with mental health problems might need. However, it is a business decision they make when they choose to take in someone with a questionable mental health status. It must also be a business decision to determine whether there are available resources

Standard 485 B (continued)

(either internal or external) to meet the resident's mental health needs if problems are identified prior to admission or during retention.

The intent of the tracking form is to not track every type of behavior, or every occurrence. Instead, the goal is to try to isolate or identify certain well established behaviors or patterns of behaviors that have shown or might be suspected to lead to a crisis situation or may be considered problematic to observers for whatever reason. A resident may exhibit a certain behavior 50 times in one day over several days. A staff may only need to document that the behavior occurred multiple times for any given day. Also, the mental health agency and the facility both decide whether a tracking form is necessary. It is not automatic.

Question: How often do behavior management tracking forms need to be updated? What about the behavior management plan?

Answer: The behavior management plan and tracking form should be reviewed and updated at the same time that the resident's ISP is reviewed and updated, or whenever it has been determined by the QMHP and facility that there has been a significant change in the resident's behavior.

Standard 485 C

Question: Who will be providing all related mental health/behavioral training to the supervisors? What form should the evidence take that direct care staff have had training covering MR, MI, SA topics?

Answer: The following information is taken from a guidance document titled "Criteria for Provider Training," dated 2/13/02. This should be used as your guidance.

The training should be conducted by an individual with verified expertise related to the training topic. Verified means documentation exists confirming that the person conducting the training has education and/or experience in the training topic.

Training may be acquired through the following:

- ✓ Accredited four year colleges or universities;
- ✓ Accredited community colleges;
- ✓ Conference workshops;
- ✓ Instructor-led training including:

Standard 485 C (continued)

- Training sessions conducted by the Division of Licensing Programs, other public or private agencies or organizations, provider associations, individuals or companies with verified expertise on the topic; or
- In-service training offered by the licensed program/facility using an individual with verified expertise on the topic to conduct or lead the training;
- ✓ Self-study programs including:
 - Training offered by the Division of Licensing Programs through such media as TV, audio, video, CD-ROM, web-based or books when the Division oversees the assessment materials and issues the certificate; or
 - Correspondence courses offered through print, TV, video, CD-ROM, books or web-based courses. The individual will maintain copies of all materials submitted to the sponsoring entity along with the certificate or letter of completion. Materials will be available for review by licensing staff upon request.
 - Use of audio, video tapes, TV, CD-ROM, web-based or books when used in in-service training, under the supervision of a facilitator with verified expertise on the course topic who can provide guidance as needed. The facilitator should determine the number of training hours to be credited to the individual.

Documentation of all training for each individual should include the name of the trainee, the title of the training, name of facilitator/instructor/training-education coordinator, documentation of the instructor's expertise, sponsoring entity, date of training, and number of contact/or credit hours of training. Documentation required by specific standards must be included.

Question: What is the requirement for staff to accurately assess psychosocial behavior that is deviant?

Answer: Standard 485 C requires staff to be trained on monitoring, documentation and intervention techniques when high risk behaviors are exhibited and to be kept informed of the status of high risk behavior. An assessment of psychosocial behavior can only be completed by a QMHP.

Standard 630 C 5

Question: Will current approval of direct care training remain?

Standard 630 C 5 (continued)

Answer: Yes. Direct care staff training addressed in the former regulations in 630 C 4 that was approved by the Department of Social Services remains approved.

Standard 630 H

Question: If a staff person is in the middle of his year at the facility, when do the 16 hours of training start?

Answer: The period of time used for the annual training requirement is the employment year, rather than the calendar year or licensure year. This means that the required training hours must be obtained within one year from the date the staff person began employment. In subsequent years, the required annual training would always be based on the anniversary of the date the person started to work at the facility. Direct care staff employed prior to December 28, 2005, which is the effective date of these regulations, must attend the number of hours of annual training required by the previous regulations during their current employment year, during which these new regulations took effect. Thereafter, they must have at least 16 hours of annual training. An example would be a staff person who had an employment date of July 15. To meet the annual training requirement, the person must attend at least 12 hours of training by July 14, 2006, as required by the previous regulations. This person must attend at least 16 hours of annual training between July 15, 2006 and July 14, 2007, and at least 16 hours in subsequent employment years. Direct care staff who begin employment at the facility on or after December 28, 2005 are required to attend at least 16 hours of annual training each year.

Standard 650 I

Question: How do we transition what were formerly annual reviews to every six months without creating a “log jam” of reviews?

Answer: For medication reviews done prior to January 2006, the next review would be required to be done one year from the last review. Thereafter, the reviews would be required every six months. For example, if the last medication review was done in April of 2005, the next review would be required in April 2006. After the April 2006 review, the next review would be due in October 2006.

Question: In conducting the reviews required in 650 I, does the reviewer have to look at the medications taken by those who self-medicate or is it like 400 Q that exempts those who self-administer all medications?

Standard 650 I (continued)

Answer: While Standard 400 Q states specifically that the annual review of all medications shall be done for all residents receiving residential care except for those who self-administer all of their medications, Standard 650 I does not specify the same exception. The intent is as follows:

For every resident assessed in assisted living level of care, a licensed health care professional, acting within the scope of the requirements of his profession, shall perform a review of all medications at least every six months.

Standard 670 E

Question: If the CSB refuses to offer mental health services, what does the facility do? Notification of a CSB does not equate to receiving services. The CSB may decide it does not meet its criteria for services. What does the facility do then?

Answer: If the CSB refuses or is unable to provide services for a resident who is its regular client, then the facility should utilize the chain-of-command for that CSB to express its concerns, e.g., the executive director of the CSB followed by the board of directors. The facility must make sure it documents all efforts made to obtain the mental health services. If the resident is not a client of the CSB, and it is believed that services are extremely important, then, again, utilize the chain-of-command to express concerns. Document all failed efforts and reasons given for the refusal to provide services. Unless a resident is at the point of doing harm to self or others, the facility is not required to discharge that resident. If the facility has determined a crisis has occurred that involves a risk of harm to the resident or others and the CSB refuses to do an evaluation, the facility should call the local police to obtain an emergency custody order. And, afterward, the facility should contact the director of emergency services for that CSB. When services are not able to be provided by the CSB for emergencies as well as non-emergencies, the licensing inspector should also be contacted.

Standard 670 E 2

Question: This really should have been part of the MH tracking guidelines. It implies it would be acceptable to retain a resident whose needs may not be met in the facility.

Answer: The services we are referring to here are those that would need to be provided by a mental health agency or person, not by the facility. The services are treatment based. Therefore, unless the resident is exhibiting an imminent risk of harm to self or others, the facility does not have to discharge the resident because the mental health agency has determined that it cannot provide the services at that time. Of course, the facility is always responsible for meeting the needs of the resident as specified in the DSS licensing standards and if it cannot, the resident must be discharged.

Standard 670 E 4

Question: If the determination is made that point #1 applies, is this necessary? This appears to encourage the facility to find a way to retain a resident whose needs the facility may be unable to realistically meet.

Answer: Again, these are mental health treatment services that the facility may not be able to obtain for the resident. The facility is expected to document its efforts to obtain the services. Unless the resident presents an imminent risk, then the resident is able to remain in the facility, provided the facility elects to retain the resident and the facility can meet the other needs of the resident. However, if the resident has been recommended to receive mental health services, the facility must continue to seek an available mental health treatment provider.